BULIMIA NERVOSA — A CASE REPORT

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SYNOPSIS

Bulimia nervosa is characterised by recurrent bouts of overeating followed by self-induced vomiting or purgation, and there is a morbid fear of becoming fat. It is an uncommon phenomenon and like anorexia nervosa the characteristic psychopathology is a preoccupation with food and weight. This case illustrates the clinical presentation and the problematic issues of management.

INTRODUCTION

Bulimia nervosa or the binge-eating syndrome is an uncommon eating disorder which has only recently been classified as a distinct clinical entity — albeit it may present as a symptom of anorexia nervosa. The Diagnostic and Statistical Manual (D.S.M.) of the American Psychiatric Association has categorised bulimia nervosa in the D.S.M. III, 1980 (1). The essential criteria for diagnosis are:

(1) there are recurrent episodes of overeating — this constitutes the most constant feature
(2) to avoid the 'fattening' effect of food, the patient induces vomiting or abuses purgatives
(3) there is a morbid fear of becoming fat

In anorexia nervosa there is a willful pursuit of thinness, disturbed cognizance of body size but a reduction of food intake resulting in severe inanition. Patients with bulimia nervosa may have a previous history of true or cryptic anorexia nervosa. Casper et al (2) found 47 per cent of female patients with anorexia nervosa periodically resorted to bulimia — Beaumont (3) reported a lower figure of 30 per cent.

Bulimia nervosa presents more commonly in female than male between the ages of 14 to 27 years. According to Russell (4), in constrast to anorexia nervosa these patients are only slightly underweight and occasionally the binge eating alternates with periods of abstinence. The overeating is the precursor of self-induced vomiting or purgation which is the patient's attempt to counteract the effects of ingesting excessive food. Amenorrhoea is not a common or persistent feature. There is no characteristic personality type preceding the illness although Dally (5) observed that bulimia occurred in patients of anorexia nervosa with obsessional personality.

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CASE HISTORY

A 16 year-old Chinese girl was referred to the Child Psychiatric Clinic by the teacher because of gross underweight and declining school performance. Outpatient management was futile and thwarted by her non-compliance and deft manipulation at home. It was deemed necessary to admit her into Woodbridge Hospital because of her emaciated state.

Born and bred in Singapore, her early developmental milestones were normal. Father died of brain cancer when she was only 7 years and mother remarried. She could not get along with stepfather and there were frequent tiffs — she accused him of being harsh, unconcerned and aloof. Mother, a rather unassertive and facile woman, was caught in the rift and in attempts to pacify any squabbles she had to concede to patient's demands which incensed the husband. Patient was the eldest of 5 children; there were 3 younger brothers and a stepbrother — among the siblings there was less friction.

During primary school she excelled academically and participated in extra-curricular activities; but in Secondary Two her work and interest plummeted. She started to have uncontrollable voracious appetite and would subsequently vomit in the toilet. Food in the kitchen was consumed in enormous amount usually at night when everyone was asleep. She complained daily of being famished and pestered mother for more money to purchase biscuits. After gorging herself, she would insert a finger in the throat to induce vomiting — she felt relieved partly because the abdominal distension had been corrected and moreover the eating would not lead to fatness. Her mind was preoccupied constantly with thoughts of food and eating. "I can't control myself — once I start eating I can't stop."

On admission she was amenorrheic for 6 months and weighed 32.5 kg (height — 1.45 m). She acquiesced that she was underweight but there was a discrepancy between her desired weight and healthy weight. There were evidences of secondary sexual characteristics with presence of downy hair over the arms and body. She had no boyfriend and appeared disinterested in the opposite sex.

A few months before admission she was investigated for fits in Tan Tock Seng Hospital, but skull X-Ray electro-encephalogram and computerised axial tormography were normal.

Management

We advocated a behavioural approach with supportive psychotherapy as the basis of treatment. Her initial weight stood at 32.2 kg and on psychometric assessment the IQ was 120.

She was only permitted to eat during meal times and supervised by a nurse. We discouraged going to the toilet during meals and a nurse usually accompanied her on post-prandial walks to prevent self-induced retching. It was decided that she could go on weekend leave if she attained 37 kg and be discharged after reaching a target weight of 40 kg (appropriate for her age, sex and height).

The first week in hospital was exacting for the staff — there were frequent outbursts of temper tantrum. These incidents occurred usually during mother's visit — she had threatened suicide if not discharged and in fact at the end of the first week she lost 1.5 kg. The nurses were advised to ignore attention-seeking behaviour and gave social reinforcement, eg. praise, whenever she became more compliant to treatment. Patient was encouraged to eat regular meals, slowly and in the company of nurses or patients so that social influences would help to restore healthy eating pattern.

During daily review by the medical staff the patient was encouraged to ventilate her pent-up emotion and discuss her future career. Themes in these sessions included problems of 'growing up' and tolerating healthy adolescent weight. The therapeutic process provided her a new inter-personal experience and trusting relationship. Mother was given supportive help on how to be firm yet understanding with daughter. After establishing rapport with the staff she became more amenable to change and on achieving 37 kg in the third week was granted weekend leave.

Her progress was remarkable in the next 3 weeks and there were no more histrionic outbursts. She was more willing to discuss her problems and relationship with mother improved. She did not resort to overeating or vomiting and weighed 40 kg after the sixth week. Her menstruation returned.

After discharge she continued to make good progress and found a job as a salesgirl in a supermarket.

DISCUSSION

The patient with bulimia nervosa is a victim of powerful and irresistible urge to overeat. The morbid fear of fatness leads to a determination to maintain body weight below a healthy level by vomiting or purging. There is a discrepancy between the weight desired by the patient and that which is determined by her constitution. Bulimia tends to be a solitary and secretive habit — the patient had bouts of overeating in ensured privacy at night. The social setting is often contrived by the patient to facilitate the habit.

During vomiting she would insert her finger in the throat to induce a gag-reflex. Russell (4) has described patient's with calluses over the dorsum of the fingers due to repeated rubbing of the skin against the upper incisors. In this patient, the tell-tale sign was not obvious. Other methods to reduce weight are purgatives, diuretics, amphetamine and excessive exercise.

Bulimia nervosa and anorexia nervosa share the characteristic psychopathology of preoccupation with food and weight. The preoccupation is an overvalued idea and not an obsessional rumination. The binge eating serves not only to satisfy hunger but also to alleviate depressive mood — but the underlying problem in bulimia nervosa is not a depressive illness. One can postulate in the psycho-pathology an avoidance of conflict or denial of problem. Conflict within this family involved the eldest child, assuming an authoritative role at home after the death of father, but had been challenged by the arrival of stepfather. Accepting him and also to relinquish authority was a difficult adjustment experience for her. Overeating can be interpreted as meeting an unfulfilled emotional need and mother's love — she complained that mother had become less concerned and understanding. The behaviour can also be viewed as a flight from the problems of adolescent identity — sexual maturation and role identity.

The grotesquea eating orgy suggests a failure of the satiety mechanism at the hypothalamus, which is influenced by psychological events. A similar model has been postulated for anorexia nervosa, that the hypothalamic effect operates in a converse direction, causing a drastic reduction in the intake of food.

Physical complications of vomiting or purging are due largely to potassium depletion. The history of fits was probably secondary to electrolyte imbalance leading to epileptic seizure (6).

Patients with bulimia nervosa are difficult to manage as outpatients and admission is necessary to interrupt the vicious circle of overeating, vomiting and weight loss.

Appetite suppressant, like di-ethyl propinol, is ineffective and trial with phenytoin unconvincing in treatment of bulimia. This patient was prescribed phenytoin for the fits but it did not control overeating.;

Establishing a trusting relationship from the outset is a prerequisite. In this case family therapy is indicated but it

may be precarious to alter the family dynamics without the participation of stepfather, who is reluctant to be involved. Short of this, individual psychotherapy could only be practised. Fairburn (8) suggests a cognitive approach by tackling problem-solving skills to help those who lack confidence and assertiveness.

Russell (4) has commented that the prognosis is not favourable because of the low level of cooperation in treatment and the intractable nature of the disorder. In this case, a year after discharge from hospital, there is no forbidding sign of an imminent relapse.

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